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ABSTRACT

Graduate education of administrators for mental retardation and developmental disability programs are defined under the umbrella of Health Services Administration. These programs have in common the delivery of health care. From the administrative standpoint, the broad area of human services must be brought down to manageable, functional segments, but must also be concerned with all of the human services. A way an administrator can relate to other human services is by first having a thorough knowledge and understanding of the health care delivery system and the role management plays within it. This initial working document deals with graduate education for administrators of mental retardation, development disability programs, and institutions. Included is a questionnaire and results that identify major functional areas of responsibilities for administrators. (Author/KE)

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POSITION PAPER

Revised Edition

EDUCATION OF HEALTH SERVICE ADMINISTRATORS IN AN INTERDISCIPLINARY MODEL

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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PREFACE

Health Services Administration is a broad field covering many specialties relating to the management of various types of health care delivery programs and institutions. These specialty fields range from the traditional institutional hospital administrator to the various administration specialties emerging in the fields of mental retardation, community mental health and other health care systems. It is argued by some that the administrator of a health care delivery system should be concerned with the whole range of human services and not just health care delivery. These individuals, therefore, feel that administrators in these newly developing program areas should be trained under a human services administration model.

In this position paper, however, the subject matter is limited to graduate education of administrators for mental retardation and developmental disability programs which are defined herein under the umbrella of Health Services Administration. These programs have in common the delivery of health care to the American public. The administrator must recognize that functions, activities and programs have to be divided into manageable units. From an administrative standpoint the broad area of human services must be brought down to manageable functional segments. At the same time, however, the administrator must be concerned with all of the human services. The authors feel that one of the best ways an administrator can relate to other human services is by first having a thorough knowledge and understanding of the health care delivery system

and the role management plays within it. The scope of this position paper is confined to the education of administrators under the health services administration model.

This position paper is intended to serve as an initial working document on the subject matter of graduate education for administrators of mental retardation/developmental disability programs and institutions. It can and should serve as a focus for discussion and debate by educators, administrators, and executives of agencies and organizations. From these discussions specific actions can be taken to further develop educational programs in this field. The advancement of such educational programs is the overwhelming objective behind the publication of this document.

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INTRODUCTION

HISTORICAL REVIEW

Health services administration is rapidly changing. There is a decided change in the labeling and training of hospital administrators. Previously training focused on "bricks and mortar" internal operations, with little emphasis on events outside institutional halls. Now the trend is to a broader training so that an administrator can go into an institutional or program setting. Part of this change is evident in the name change of hospital administration courses to health administration.

There are many specialty areas under the broad umbrella of Health Services Administration. Such a list might include, but would not be limited to, 1) hospital administration, 2) nursing home administration, 3) clinic management, 4) mental health administration, 5) mental retardation administration, 6) developmental disability administration, 7) diagnostic and treatment center administration, 8) health planning, 9) health regulatory agency administration, 10) public health administration. Some of these areas are primarily institutional, others primarily programmal and others are a combination of both. This position paper addresses itself primarily to two of these areas; mental retardation administration and developmental disability administration. Included under these two areas are institutions for the retarded, deinstitutionalization programs, community D.D. programs, state and regional D.D. program coordinators, numerous developmental disability, diagnostic and treatment programs, group care homes and university affiliated facilities. Although the Federal definition of developmental disability includes mental retardation, in this position paper both terms are utilized since

there is still considerable debate and conflict concerning the definition of developmental disabilities. It should also be recognized that many developmental disability programs do not receive federal funding, and thus are not bound by this definition. They serve many populations or sub-populations not included in the federal definitions. The federal definition of developmental disabilities is contained in Public Law 94-103, the "Developmentally Disabled Assistance & Bill of Rights Act," which includes only the severe and profound cases of MR. This eliminates all social and cultural retardation and mild mental retardation. The definition also includes epilepsy, cerebral palsy, autism and dyslexia. Recently efforts have been made to add learning disorders.

Most organizations working with developmental disability dollars are actually working with very modest kinds of funding. Title I, Part C of the Developmental Disabilities Act, which has to do with coordination of state funding within the states, has brought about some influence that is impressive when the amount of the money spent is considered. The other part of the Developmental Disabilities Act, however, is the service delivery system which involves the University Affiliated Facilities. Some people argue that developmental disabilities is, in fact, a service delivery system, but there is very little evidence of such a system. If one looks at the direction developmental disabilities is going it needs to be considered in relation to the service systems.

Although a number of groups and knowledgeable individuals within the field of mental retardation and developmental disabilities have all expressed the need for better education of administrators there has been

little agreement on how this need should be met. The administrators group of the University Affiliated Facilities (UAFs) is one element concerned with educating these administrators. For the last two years, authors of this position paper, as administrators of UAFs have been working to find ways of meeting this need. It is anticipated that the recommendations listed in this position paper can establish a direction for future training of entry level administrators into the specialty areas of mental retardation and developmental disabilities.

ADMINISTRATOR'S TRAINING PROJECT

The effort which culminated into this position paper was begun in May of 1973. A group of concerned UAF administrators first met in Denver, Colorado to develop a core curriculum of administrative subjects that all disciplines within University Affiliated Facilities should be taught. At this meeting the need was also expressed for upgrading the skills of existing UAF administrators. The possibility of funding a management improvement workshop from the Bureau of Community Health Services, Health Services Administration, DHEW was discussed and the administrators were successful in obtaining funding for such a workshop. The University of Oregon Health Sciences Center acted as the fiscal agent. The planning committee consisted of:

Jerry O. Elder, Project Director, Administrator, Child Development and Rehabilitation Center, University of Oregon Health Sciences Center,

R. Wilburn Clouse, Asst. Dir. for Admin., J.F. Kennedy Center for Research on Education and Human Development, George Peabody College,

Ron Thorkilson, Administrator, UAF Exceptional Child Center, Utah State University,

Ed Oncrati, Associate Director for Administration, Mailman Center for Child Development, University of Miami.

This committee was established to set up and coordinate the workshop. Maximum participation from all UAF administrators was solicited regarding topics for discussion at the workshop. The workshop was held in New Orleans in November, 1973 in cooperation with and the help of the Graduate Program in Health Services Administration, Tulane University School of Public Health and Tropical Medicine.[1] At this workshop, which was the first opportunity for the 45 UAF administrators present to meet separately and discuss mutual problems, it was evident there was a need to better educate existing administrators and also those coming into the field. A small group of administrators expressed their willingness to volunteer to serve on a committee to do work on this problem.

Impetus for the next step came in April, 1974 when the Bureau of Community Health Services funded a grant application to extend the effort that was started with the workshop. The administrators who had volunteered to serve on the planning committee first met in May of 1974 at the AAMD annual meeting in Toronto. This planning committee consisted of:

Jerry O. Elder, Project Director

R. Wilburn Clouse, Associate Project Director

J. Robert Gray, Administrator, Division of Disorders of Development and Learning, University of North Carolina

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[1] Proceedings of this workshop were published. Single copies can be obtained from the Child Development and Rehabilitation Center, University of Oregon Health Sciences Center.

Vic Keeran (Charles V. Keeran, Jr.), Associate Director, Administration
The Neuropsychiatric Institute, Mental Retardation Program,
UCLA

Melvin D. Peters, Administrator, Child Development Center, University
of Tennessee

Adrian E. Williamson, Administrator, John F. Kennedy Child Develop-
ment Center, University of Colorado Medical Center,

(Another member, Mr. Thomas A. Knox, who was an Administrative Resident at the John F. Kennedy Institute for Rehabilitation of the Mentally and Physically Handicapped Child in Baltimore, Maryland, originally served on the committee. Mr. Knox took a position with a Professional Standards Review organization in August, 1974 and, therefore, left the committee at that time).

The objectives of this project were four-fold:

1) To assess the educational and experience competency of existing UAF administrators.
2) To maximize the involvement of existing UAF administrators in the development of this project.
3) To develop a curriculum for training new UAF administrators which would lead to a master's degree in Health Administration.
4) To develop appropriate mechanisms for upgrading the managerial skills of existing UAF administrators.

After the project had begun, it became apparent there were a number of problems connected with these objectives. The overlying one was that the project's scope was too narrow -it dealt only with UAF administrators.

The project's direction was expanded to include administrators of mental retardation and developmental disability institutions, programs and similar multidisciplined type programs. Becuase of the emphasis on training in UAFs and because they are excellent interdisciplinary training laboratories, it was felt that UAF administrators have a responsibility for developing administrative education in the MR/DD fields.

The first two objectives were accomplished through the development of a questionnaire which is described elsewhere in this position paper. The third objective was premature in that after the authors initiated the project and learned of other efforts in the field, it became obvious that they were presumptuous to believe that they could develop a set curriculum that would be accepted by graduate programs in health care administration or any funding agency. This objective was modified and now reads: "To examine the current status of graduate program education for administrators of mental retardation, developmental disability and similar multidisciplined type programs to determine how the need for educating entry level administrative positions can best be met". The fourth objective was expanded to include all DD and MR administrators and is being accomplished in conjunction with the Task Force on Mental Health and Mental Retardation Administration. A separate report will be published in the spring of 1976 concerning the continuing education aspects of both mental health and mental retardation administrator education.

Efforts for the training project began in April, 1974 when the project director, Jerry Elder, attended a session at the annual meeting of the Association of University Programs in Health Administration

entitled "Models of Mental Health Administration". This was the first time that AUPHA held a separate session on mental health administration education. Information on four programs in various stages of development or operation was presented at this meeting. A major concern expressed at the session was that no research had been done on whether there is any difference between a mental health or a mental retardation administrator and general health administrators. A question was raised as to what is administration in mental health and is it unique to general health administration? The group could not agree on what is included in administration.

The first meeting of the UAF administrator's project planning committee was held in Toronto at the AAMD meeting. At that meeting a general plan was laid out on how the project should be approached. It was decided that Mr. Elder should travel to Washington, D.C. to meet and discuss with various individuals who have an interest in the area of training administrators for developmental disability programs. In August, 1974 Mr. Elder met and talked with the following individuals:

Don McNamee, Administrator, Eunice Kennedy Shriver Center, Boston, Mass. Mr. McNamee had been working with Mr. Keeran at the request of the UAF Committee of the National Advisory Council on Developmental Disabilities to develop a training proposal based upon a model of Human Services Administration. However, to date no proposal has been submitted.

Patricia Cahill, Long-Term Care Director, Association of University Programs in Health Administration, Washington, D.C. It was felt that the project should coordinate its efforts with this professional organization since they represent the major graduate

programs in health administration throughout the country. Pat Cahill is also the staff person who coordinates the activities of the Task Force on Mental Health and Mental Retardation Administration.

William Wilsnack, President's Committee on Mental Retardation, Wash. D.C. In the past the PCMR had worked on and had submitted a proposal for an administrative training program. It was submitted to the secretary of HEW but the procedures which they had proposed were not accepted and it was never approved.

George Bouthilet, Ph.D., UAF Representative, Developmental Disabilities Division, SRS, Washington, D.C. Dr. Bouthilet was very interested in our project. He was helpful in pointing out other individuals and agencies who have expressed an interest in training administrators in developmental disability programs.

Jean DeBell, Director, Research Management Improvement Program, National Science Foundation, Washington, D.C. NSF is concerned with, and has funded a number of management training projects. One of the major areas is the building of management compentencies. This is felt to be a potential source of funding for any training programs that might be developed.

Dr. Saul Feldman, Director of the Staff College, National Institute of Mental Health. Because of Mr. Elder's conversations with Dr. Feldman and Pat Cahill, he was able to be invited to the First National Conference on Education for Mental Health Administration which was held in New Orleans in early March, 1974.

This coordination with the mental health administrator education efforts has been both valuable and fruitful.

James Papai, Chief, University Programs Section, Division of Health Services, Bureau of Community Health Services. These discussions centered around possible funding of any training proposal that might be developed.

Robert McNeill, Executive Director, American Association of University Affiliated Programs (AAUAP). Bob McNeill has also served as a focal point for coordinating the project's efforts with other agencies and keeping them informed of our activities and vice versa. His office was used as a working headquarters during Mr. Elder's visit in Washington, D.C.

The next step was the development of the questionnaire. Mr. Elder and R. Wilburn Clouse, Associate Project Director, met in August to develop the initial draft for this questionnaire. The questionnaire was sent to the other committee members for their comments and was reviewed by other UAF administrators at the annual meeting of the AAUAP in Valhalla, New York.

Since Mr. Elder and Mr. Keeran would be attending the first National Conference on Education for Mental Health Administrators, it was decided to postpone a curriculum development meeting with consultants from graduate programs in health administration until after that conference. This was fortunate, since we realized, as a result of that conference, that the committee was premature to try and develop a curriculum that could be accepted by graduate programs in health care administration throughout

the country. Because of the similarity between problems of mental health administrators and mental retardation/developmental disability administrators, it was decided to change the focus of the curriculum development meeting to one of examining the current status of graduate education programs and how it could best meet the need of training administrators without prior experience for entry level positions into the field of mental retardation and developmental disability administration. Another reason for not developing a set curriculum at this meeting was that we were moving along much faster than the Task Force on Mental Health and Mental Retardation Administration. It was felt that we should retrench and try to fit into their time schedule since the peculiarities of administration in these two specialty areas are very similar.

The authors, along with James Papai, Chief, University Programs Section, Division of Health Services Training, Bureau of Community Health Services met in Denver, Colorado March 24 and 25, 1975 with representatives from the following programs:

Gordon D. Brown, Ph.D., Professor in Charge, Graduate Program in Community Systems Planning & Development, Pennsylvania State University.

Walter M. Burnett, Ph.D., Director, Graduate Program in Health Services and Hospital Administration, Tulane University Medical Center.

Patricia A. Cahill, Director, Office of Long-Term Care, Association of University Programs in Health Administration.

John E. Kralewski, Ph.D., Director, Program in Health Administration, Department of Preventive Medicine and Comprehensive Health Care, University of Colorado.

John R. Malban, Project Director, Mental Health Administration Training, Program in Hospital and Health Care Administration, University of Minnesota.

These individuals represented various styles of graduate programs from schools with different philosophies. It was an excellent group and everybody during the two-day meeting was very congenial and helpful. The consultants all complimented each other on their contributions to the meeting and lively interchanges of opinions and program philosophies were exchanged. This kind of interchange was extremely productive; to be able to sit down and rap in a small group for two days with administrators on one side and educators on the other side.

PROJECT RATIONALE

There has been much rhetoric concerning the need for better training of administrators in the developmental disability and mental retardation fields. The National Advisory Council on Developmental Disabilities and the President's Committee on Mental Retardation are just two of the major bodies which at one time or another have expressed the need for developing administrative training capability in these areas. The documentation of this need, however, has not been established and the exact number and type of administrators needed has not been demonstrated. The questionnaire that was undertaken as part of the administrator's training project did address itself to health services administration manpower and status needs. The results of the questionnaire, presented in detail in appendix A, show that in those programs which responded to the questionnaire the following new administrative positions are planned in the next two to five years.

Degree Level	No. of New Positions
Baccalaureate	152
Masters	167
Doctorate	67

No real conclusions can be drawn from this except that from the 170 questionnaires that were returned, 234 post bachelor positions will be created in the next two to five years. This gives some indication of the need there will be for trained developmental disability and mental retardation administrators in the coming years. Although the questionnaires were not coded to determine whether these 170 responses came from separate institutions and programs, it is known that there was some overlap. It is safe

to estimate, however, that at least 100 different programs or institutions are represented from these 170 responses. It is easy to see from this small sample if there is a need for 234 post bachelor administrative positions from 100 different programs what the scope would be if projected nationwide.

The need to place well-educated administrators in these new positions should be fairly obvious. However in the past many persons have been placed in these positions with inadequate administrative training and, in some cases, little desire to be an administrator. The authors of this position paper feel that an administrator should be both committed to the values of the field into which he is going and have the necessary educational background to fill any administrative position.

The University Affiliated Facilities can provide excellent laboratories for practicum working experience, the kind that is essential for administrative interns or residents in the mental retardation or developmental disability fields. Each UAF is similar in some ways and different in others. Each has operations that are responding to certain sorts of conflicts and pressures that determine it. One of these has to do with the fact that UAFs are obviously interdisciplinary project oriented. This creates conflicts within academic institutions since it is always coming counter to the departmental base structure. This has some definite training advantages; however, since realities of a community based program are project oriented and not departmental oriented. Therefore, the student can gain insight into this orientation in the UAF.

Another unique aspect of the UAFs that make them an ideal basis for the practicum experience is the carrying out of the organizational mission.

Because of the complexities of the type of handicapping conditions seen in a UAF, the only way this can be accomplished is through team finding, team staffing and team management. This goes back into the history of rehabilitation institutions, state mental health hospitals, state schools, etc. The UAFs are now institutionalizing this as a training model. UAFs can provide the student in a graduate program in health care administration an excellent example of the type of realities he will be dealing with after he finishes the practicum experience.

If advocates of each of the specialized fields under health services administration were gathered together, each would undoubtedly argue that their own field is unique or different from the others. Is this uniqueness significant enough to justify separate educational programs to train administrators in each of these fields? The differences in administration of the various specialty fields is an area of research that needs to be investigated. Because there is no concrete empirical data to indicate whether mental retardation and development disability administration is or is not unique, the authors can only go on their own feelings, attitudes and experiences.

There are some distinctive characteristics in the MR/DD field that modify the nature of the administrator's function. Because of these differences and because of the changes that are occurring in graduate programs for health administration, the authors felt the need to develop a position paper rather than a simple report. We hope that this position paper can both point out some of these distinctive characteristics and show how they differ or agree with other specialty areas. We also hope

to influence the direction of graduate program education for administrators of specialty programs under health administration.

POSITION

As a result of the investigations undertaken by the authors the following positions have been determined:

(1) The fields of mental retardation/developmental disabilities, and mental health have characteristics that make them distinctive enough to justify unique training formats for their administrators.

(2) Existing graduate education programs in health administration are a logical place to most closely meet the needs of educating administrators in the specialty field of mental retardation/developmental disabilities. However, these programs have historically been operationalized around single discipline institutional models and are not equipped to deal with the multidisciplined environment of MR/DD administration. These graduate programs are currently not meeting the needs of educating MR/DD administrators.

(3) Through joint efforts between individual graduate programs and UAFs and through the organizational efforts of the Association of University Programs in Health Administration and the American Association of University Affiliated Programs, graduate education programs can be modified to meet the needs of educating MR/DD administrators.

(4) There are enough similarities between administration in the fields of mental retardation/developmental disabilities and

mental health to advocate close cooperation and coordination in developing educational programs for them.

REVIEW OF ISSUES

EDUCATION OF STUDENTS

The demand for well-trained administrators in mental retardation and developmental disability programs and institutions has created a dilemma. The demand at the current time is for a generalist or the top administrator. However, there are not enough adequately trained people with the proper experience to fill these positions. It is rather foolish to believe that a student without prior experience in the field, coming out of a graduate program in health administration, can assume this top spot in all but a few of the small community organizations. Individuals coming out of graduate programs should instead be moving into second or third echelon positions to gain the necessary experience in order to later assume the top management position in an organization.

On the other hand, clinical staff who have not been adequately trained in administrative skills are currently assuming top management positions. (This problem will be spoken to in a separate report on continuing education.)

There was sentiment expressed at the Denver meeting against labeling the type of person we are talking about as a developmental disability or mental retardation administrator. It was felt that this was too restrictive. Instead, it was felt this person should be called a health services administrator. Here, a number of options are available depending upon the particular kinds of health administration the student is interested in or sees himself functioning in. The Developmental Disability Act specifies certain conditions in its definition of DD. This definition

is unnecessarily restrictive in terms of administration of DD programs. There are a number of programs in the health services field that have similar requirements in terms of knowledge, skill and function, and some of these are not in the area of mental retardation, developmental disability or handicapping care.

The field of hospital administration is gradually changing its philosophy from hospital to health administration. It allows within that option for the student to socialize into some area outside the hospital. In the field of health services administration there are, of necessity specialized areas. However, there is a common body of knowledge that everyone within this area needs to know or at least be aware of, such as basic organizational issues, financing, management concepts and other areas that are mentioned under the broad curriculum outlined in the questionnaire results.

A hospital administrator is now a different type of health administrator because hospitals are no longer existing in the isolation they once did. If today's hospital administrator does not know how to relate to community agencies, to governmental agencies, etc., he is not doing his job. He is specialized, however, in that he is different from the individual who runs a community based health services clinic of any kind. These are different focuses stemming from the same general body of administrative knowledge.

It was argued at the Denver meeting that for the sake of semantics, much administrative education is common to most, if not all, areas of administration. This has to do with certain kinds of generic decisions which are basic to management. It doesn't matter whether you are managing

a movie theater or a state mental hospital, or whether you are worrying about elective surgery admissions. One has to understand the context of management and there are some things that go across the board when one is dealing with health. The manager has to be able to pull these kinds of things out, know some of them and how to deal with them when he is confronted with them five years from now. However, one can't build a capacity for dealing with context as easily as one can build a capacity for dealing with certain generic kinds of decisions, and it appears that building that capacity is a matter of sophistication that comes with experience.

A good manager will gain in time, the maturity and experience to assume a top management position. However, a student fresh out of a graduate program does not normally start there. When it comes to the nitty-gritties of managing an organization, probably 80 percent of it is in common generic terms, but the other 20 per cent that is unique must be learned in the field in which a person is working.

A question was raised during the Denver meeting: When one considers an organization that is putting together a large number of disciplines (education, social aspects, rehabilitation, etc.), who is the executive director of this organization and what is his discipline? Is it a health discipline at all? It was concluded that this person could come from various disciplines but the prerequisite is that he must have broad administrative skills. However, it was felt that for entry level positions, since the most common element within these organizations is health, that he could well come out of the health services administration graduate program. The student, however, must be made aware of the totality of

human needs. As an example, if you are an architect, you should not design a building that just looks beautiful; you must realize that people will live in it and they have to get to the bathroom and some are in wheelchairs and some are seven feet tall. Having a regard for human interest and what he is designing doesn't mean that the architect runs the educational programs of the health programs or anything else. He just needs an awareness of human needs, at least human actualities. Also, those concerned with social welfare must realize the impact of economic factors, health factors, education factors, etc. Somewhere in between the two definitions of human services administration and health services administration there is another concept which was coined in Denver; interdisciplinary program administration. This is where the University Affiliated Facilities can serve as an excellent training model for students in health services administration.

There was argument during the Denver meeting for adopting the human services model and a graduate program with this philosophy. But to deal with it, it was necessary to limit the direction to health services administration. The concern was with the person in the top spot, the overall administrator of an organization, and that he be able to cope with those things he is managing.

Others felt that we were thinking too provincially if we were to restrict our curriculum discussions to a health services administration program. Some felt a public administration curriculum would work just as well. In essence they were saying that the pedigree that the individual comes out with is not absolutely crucial to the field. It could be a master's in public health or business administration or a major in public

administration or health care administration. The important thing is that the individual have a graduate degree in administration and a curriculum relevant to the mental retardation and developmental disability field. As long as the basic administrative curriculum is there academically, the entry into mental retardation or DD can be provided at the practicum level. The University Affiliated Facilities can provide that component.

An interesting item that came out of the first National Conference on Education for Mental Health Administration in New Orleans, March 5-7, was that six out of the twelve small groups in which discussions took place, indicated that too much had been made of the point that mental health administration is a specialty. In fact, there was more generic subject matter in mental health administration that met the eye. The consensus was that the Task Force on Mental Health and Mental Retardation Administration should look at generic subject matter, not to re-invent the wheel, but to capitalize on a body of knowledge already there.[2]

A COMPARISON BETWEEN MENTAL HEALTH AND MENTAL RETARDATION ADMINISTRATION

Historically the mentally ill and mentally retarded were often served by the same system. Parents of retarded children, however, started questioning whether or not their interests were being adequately met via the mental health model. In some states there were separate programs for the retarded. This decision was reinforced by organizational changes at the federal level. Nevertheless, when considering the administrative requirements, some assume no differentiation is required in the preparation of

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2 Patricia A. Cahill, "First National Conference on Education for Mental Health Administration", unpublished final report, June, 1975.

administrators. Others hold that mental retardation and other developmental disabilities are so different as to necessitate specialized curriculum educational experience. Therefore, at the Denver meeting this topic was explored in some detail and a transcript of portions of these discussions follows.

Vic Keeran indicated that he has moved back and forth between both the mental health and mental retardation systems. In his current capacity as Associate Director, Administration, NPI, UCLA, he serves as the administrator of programs in mental retardation, child psychiatry, adult psychiatry and neurology. Vic initiated the discussion by describing some of his observations. (His remarks have been edited to improve the written communication.)

Mr. Keeran:

"My comments are directed towards differences in the two systems which must be appreciated in planning the education of administrators. I will not be concerned with how these differences should be acknowledged in the educational process; that can be addressed later. Instead my remarks are intended to initiate this portion of a discussion to determine whether or not there is a general agreement on the nature of these differences.

Let me start by identifying my own bias. I believe that there are differences, but they are differences of degree not kind. As I see it, areas of uniqueness between the two systems can be traced to four basic factors: (1) Chronicity or the length of time the individual will require services, (2) The probable age of entry into the system,

(3) Consumer involvement and, (4) The proportion of multi-system involvement. My comments will focus on each of these factors.

A. Chronicity of Length of Time in the System

When individuals enter the mental health system the assumption is generally made that they will be treated, move through the system, and back into society with no further need for service. However, it is recognized that a certain number of the mentally ill will require long term care and rehabilitation. Interestingly enough those who will require long term care cannot be identified by symptoms or characteristics. They are gradually identified by a very pragmatic process -- the fact they continue to need services from the system.

By contrast individuals who enter the mental retardation/developmental disability systems are ordinarily viewed as people who will require services for a long period of time. The primary variable is not service versus no service, but type of service, intensity, and length of the interval. From the beginning, plans are made to accommodate the needs of this individual and the family for a significant time, if not for his/her entire life. However, it is found that a small proportion will improve rapidly and no longer need the system. These individuals are usually identified programatically, i.e. through the termination of their need for services from the system.

B. Age of Entry Into the System

Most individuals enter the MR/DD systems as children. By definition the conditions which cause mental retardation are present at birth

or are manifested during the developmental period. There is a well known clustering of diagnoses by age -- conditions that are evident from birth to the end of the first year; those that become evident in pre-school years and those that are identified in connection with the educational systems. One rarely hears of an adult entering the system for the first time. This factor produces a number of attendant modifications in the characteristics of the system. Clearly entry programs must be geared to all of the problems of children -- childhood illnesses, immunizations, education and healthy growth and development. In addition the system must accommodate to the interaction with the parents of the client, and with all of the associated psychological, social and legal implications.

Programs are likely to be geared to the needs of children for another reason -- our societal bias as expressed by caretakers at all levels. Since many individuals equate retardation with arrested or delayed development, there is an inclination to relate to the retarded as children regardless of their chronological age.

There are, of course, programs for mentally ill children. Aside from the acute-chronic issue discussed earlier, there is a great commonality in the characteristics of the two systems. The largest differences are noted in the adult programs. These differences are primarily referable to the age of entry into the system, pre-care levels of development, pre-care socio-economic roles and probable duration of care.

C. The Role of the Consumer

We are all aware of the growing voice of the consumer. However, I believe that the parents of the mentally retarded and other developmentally disabled constitute one of the strongest, best organized, influential groups of consumers of any of the human services. They play important roles in legislation, political and court action, and serve as strong advocates. Systems that serve the mentally retarded and developmentally disabled must be organized and administered in light of this high level of organizational sophistication and provide accountability to parents as consumers.

There are growing activities among consumer groups and legal advocates of rights of the mentally ill, but they are unlikely to reach the level of importance of the MR/DD consumer groups.

D. Multi-System Involvement

I have characterized those who enter the MR/DD systems as children who will require a variety of services over a significant portion of their life span. These services may include substitutes for family living, specialized educational facilities, specialized recreational resources, vocational and employment services, psychiatric services or any of the health care services for acute or long term disorders. The administrator might manage a direct service agency, or be responsible for planning, coordinating or integrating elements of a broader network of services. Therefore, it is likely that those working in MR/DD agencies will at least have to link with a greater variety of

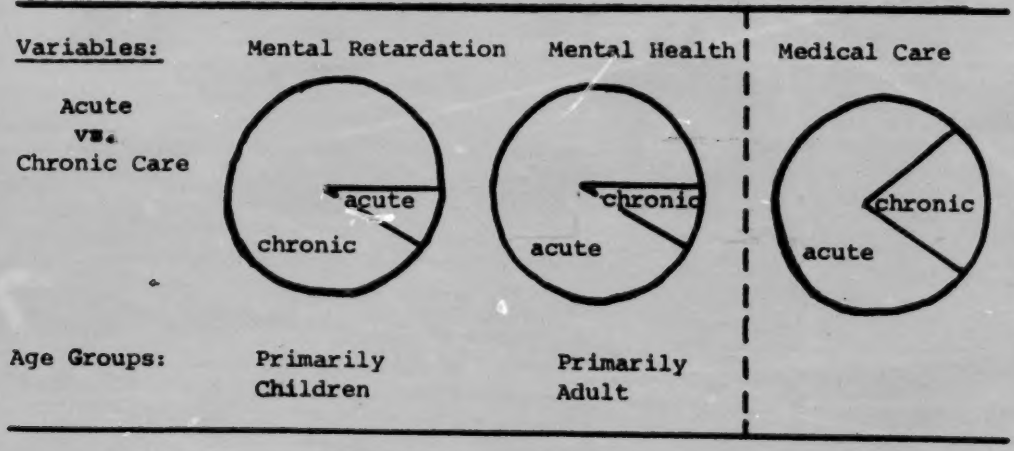
agencies and are more likely to need strong operating ties to agencies that operate under the sponsorship of another type of system.

The administrator of MR/DD facilities may also find more varied streams of public funding requiring accommodation to a broader variety of funding agencies.

In summary, I believe these are matters of degree rather than differences in kind. Furthermore, I believe that rather than the mental health-mental retardation paradigm, a better distinction is drawn when analyzed by a fourfold matrix consisting of problems of adult and children who need acute or long-term care (exhibit 1). In any event, it seems that a great deal of further discussion is required before intelligent conclusions can be reached about the implications for education of administrators."

EXHIBIT 1

A Comparison of Health Care Delivery Systems



Dr. Brown:

"I would almost include another box in your illustration which would be the traditional medical care model and I think it would even serve to accentuate the differences."

Dr. Burnett:

"I think it's even more than that, If we had a little different audience here and we went through the same exercise, what you would do is have the acute hospital where you've got mental health and exactly the same arguments would be made in the contrast. The linkages, the total services, the age, the nature of the staff, etc. The other thing that I don't see in your scheme is the very heavy dependence of both these sectors on public funding on a tax base."

Mr. Keeran:

"That's very important. I think MR is even more dependent than mental health on public funding. You go to the American Hospital Association Psychiatric Services Section and you increasingly get exposed to the guys in private sector. MR is buying a lot more of the acute services than it used to. This area is starting to accept the concept of case management and purchase of services is getting a lot more people to the private chunk of this than there used to be 3-5 years ago."

Mr. Papai:

"That depends on who's doing the buying. If you're still talking about public money, which is buying from what you call the private sector, I don't really consider that private sector. It's just another name for a public....."

Mr. Keeran:

"I would disagree with you, Jim, from the point of view of the administrator. If I'm sitting out there in ABC intermediate care facility and it worked back to the private enterprise system, you may be buying from me as the director of a regional center, but you don't have the same problems I have around cash flow, around the....."

Mr. Papai:

"The basic statement was in terms of publicly funded and I think one has to bear that in mind."

Dr. Burnett:

"But let's explore this a little further. First of all we started with a basic statement. Essentially the health industry is a public service industry in that the great bulk of it comes from public monies without a doubt, as our friend the economists have shown us time and time again. The question which then is raised when you're talking about organizational behavior is the form that that funding takes. That funding can take place on a contractual basis where you can negotiate the ground rules, for example Title VIII reimbursement, although I guess not too many people think that is very negotiable. Or it can be a budgetary process where you have a series of line items that could turn into contracts from the Federal Government or appropriations from State Government. The organizational behavior is very different in those two kinds of settings. What we see, I would argue particularly in the disabilities area, is a very heavy dependence upon the budget. This amount of money is appropriated to do X, Y and Z, whereas if you move into some other area, you get into

the negotiations of a contract as part of a broader income-producing strategy. It seems to me that's absolutely crucial in understanding how these work."

Mr. Keeran:

"It would apprear to me that there are many more similarities between long-term care and mental retardation issues than acute and mental health issues."

Mr. Papai:

"I'm not so sure this isn't the point I was trying to show you between institutional vs. non-institutional kinds of concerns."

Dr. Brown:

"A lot of it has to do with what they assume about the environment, which is the thing we spend a lot of time looking at. In other words, in the model of mental retardation you really focus a great deal at the environment, how you make the educational environment adaptable to this individual, the specific characteristics, how you make the job environment. In fact, under the Department of Labor now they have requirements for matching funds to programs which employ certain numbers of DD people, if they get federal funds. So you are really trying to adjust the environment as opposed to adjusting the individual to fit back into a traditional environment. It's been the acute care or medical model though, I would agree, that is changing in this direction because there is more chronic illness and long-term care."

Mr. Keeran:

"Once the philosophy shifts to health care as a right rather than for

those who can afford to purchase care, it seems to bring a lot of this together."

Dr. Brown:

"I agree; in fact, in the two areas you still have on the board you're saying does the DD have an educational problem or is that a health problem? It's pretty damn difficult."

Mr. Malban:

"Why do you have to make that distinction.....?"

Dr. Brown:

"I'm saying you can't."

Mr. Malban:

"But you have to."

Dr. Brown:

"You use the health services model by default. That's what I disagree with."

Mr. Elder:

"Because of why?"

Mr. Papai:

"Because as administrators we must recognize that things have to be in manageable units and I don't see any quarrel whatsoever between looking at a child with whatever kind of DD and saying that he has many needs, among which are education, social services and health, etc. But the realities are that no one person can know enough about all those fields to do everything. No one agency, private or public has responsibility for all those fields and even like HEW, which comes the closest for obvious reasons, it has got to have specialized

agencies and within that, specialized people who understand the nature of the problem they are dealing with. So, from an administrative standpoint, you've got to break it down to manageable functional areas. I speak to the health services area because that is what I represent. I don't think that means at all that we don't recognize or support the necessity for educational components, rehabilitation components, social components, whatever they may be and that there is an inter-relationship. I don't think that I or any other one person can know enough about all those things to do it all."

Mr. Gray:

"No one person has to know it. The UAF....."

Mr. Papai:

"Then, this is all I'm talking about. Within this complex, we're talking about people who know those kinds of concerns within health services administration.

Mr. Gray:

"The UAF incorporates all those resources."

Mr. Papai:

"Precisely, which is wh' I think it is the most marvelous training resource we have going."

Mr. Gray:

"But it's not limited to health services."

Mr. Elder:

"But it is on a relatively small scale."

Mr. Papai:

"It is on a relatively small scale. Within that though, if you're training a health services administrator, which is what I hope we're

talking about, he is being trained in a situation where he is exposed to and must work with the other kinds of programs that have impact on the total services that child needs, which is why it's a beautiful training resource, but you are not training the person in the health services field to become an educational administrator. There are other people with other concerns that know better the demands of the purely educational kinds of processes. You're training a person though that knows enough about the educational needs to work with the people in education."

Miss Cahill:

"I heard George Tarjan describe it beautifully, I though when he delivered the paper for us last year and he said it's a case of looking at the whole human being and while you may be primarily responsible for the delivery of a given set of services, you are well aware of the variety of needs that affect an individual and how you can facilitate for him getting those services or getting money to provide him those services. You know the whole bag, but you're not immediately responsible for it.

Dr. Brown:

"I'd like to respond to that in two respects. Just some observations and I don't agree with them or disagree with them. The example you give, first of all, has been describing what has been and I'm not sure that's going to be a reflection of what should have been or what is going to be. I think there are new models of community services - social services in communities are evolving and one should be cognizant of those. In addition, in terms of setting up an academic model,

I think that if one accepts this argument, one specializes in one area, but there certainly is a very rich mix of concerns. This would support even further the human services model where people are trained together and we don't have to go through what we did in hospital administration and planning where we had separate graduate programs and they are literally trained to be threatened and trained to hate. It's true. For example, in our program we have people on mental health traineeships who learn health, justice and welfare. What you say is true - they do have a different bias, a different professional orientation and they get into some violent arguments. Within the academic model, this is just a health problem. They say, well hell, it isn't either, look at all the money we have in justice, this is really a justice problem."

Mr. Papai:

"What you are really saying is that these things inter-relate and that's the concept Dr. Tarjan expressed very eloquently and which I am trying to....."

Dr. Brown:

"All I'm saying is that I think we ought to question very seriously the separating out of academic models into separate isolated ac:demic....."

Mr. Papai:

"I'm not suggesting that academic models be separated out. What I'm saying is if we know how to do something, we've got to have some specialization, because nobody can conquer the Universe. I think on a relatively lower scale, the concept that you were just expressing about people arguing over "it's this one," or "it's this

concern or that", is what's happening within UAFs. We have many different disciplines concerned with health, education and rehabilitation, etc., and the whole point of training them together in that one center is so they develop an appreciation of the totality of what's needed. We do not, however, try to train the social worker to be a nurse or to be a psychologist, but she's trained with those people so she understands their professional input. She still comes out a social worker and the psychologist comes out a psychologist, but you're hopefully giving them some better understanding of total needs."

These discussions are a good example of the excellent contribution that was made by all those in attendance at the Denver meeting. In summary it would apprear there are two major differences between mental health and mental retardation administration. In mental retardation there is a necessity to consider and sometimes manage a larger variety of services than just health and illness. This means dealing with other agencies and other disciplines (such as special education, vocational rehabilitation, social welfare) and the funds involved with them. The other difference is a greater involvement of consumers in the mental retardation field.

However, there are many more similarities between mental health administration and mental retardation administration than there are differences. There are a number of programs in the health services area that have similar requirements in terms of knowledge, skill and function. At the recent National Conference on Education for Mental Health Administration, most of the administrators in attendance were managers of

mental health institutions and organizations. A number of individuals were also administrators of mental retardation and developmental disability programs. There was no debate whatsoever between differences of these two types of programs as far as administration is concerned. It was discovered at that conference that although an administrator for a community mental health center and an administrator of a large state system were looking at administration from two different vantage points and NIMH was looking at it from an overview of the field, the kinds of problems they related (in terms of administration for program and facilities) were very repetitive. For example, they all discussed bureaucratic tangles similar to the bureaucratic tangles of universities. They also mentioned finances and combining a variety of financial resources and the problems of dealing with a variety of professionals. Consumerism was also a big problem along with evaluation and accountability. However, by the end of the first day the participants had had their fill of a discussion of administrative function. They wanted to get at more specific issues on education for the field. They really wanted to get into curriculum development. How does a person get the knowledge and skill and at what level in the educational continuum would this be given? These were the kinds of questions that participants at that National Conference were asking. On the final afternoon a panel began to get at this question but this was at the end of the program and they were only able to begin discussing these questions. This is currently the same situation in which the authors, as administrators of UAFs, find ourselves.

The papers which were presented at that conference pointed out many types of problems which mental health administrators experience. These are also the same ones experienced by administrators of mental retardation and DD facilities and programs. Although there are very distinct and different program concepts between mental health and mental retardation, the problems that administrators experience in managing these organizations are almost identical. To illustrate this point, excerpts from a paper presented at that conference by Dr. Saul Feldman, Director of the Staff College at NIMH are included here.[3] In his paper, Dr. Feldman presented eight distinctive characteristics that substantially modify the nature of a mental health administrator's task. If, as you read through them, you simply substitute mental retardation or DD in the place of the words mental health for each of these characteristics, you will also have a description of the distinctive characteristics of administrative problems in the field of MR/DD administration.

"While sharing a common base, administration in mental health differs from administration in other even similar areas because the mental health field has distinct characteristics that substantially modify the nature of the administrative task. These include:

First, mental health services are dependent upon public funding and are frequently subject to a high degree of governmental regulation. Administrators of these services must therefore understand the political process and be able to work closely with government at all levels. While the degree of involvement varies between political jurisdictions, both the constraints and opportunities inherent in

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3 Saul Feldman, "Administration in Mental Health: Issues, Problems and Prospects," Unpublished Paper, March, 1975.

close ties to government are omnipresent in mental health administration.

Second, the typical staff in a mental health organization is multi-disciplinary, professional and highly autonomous -- a bit like a navy with more admirals than ships. Disciplinary rivalries, conflicts around status and salary differences and a professionalism that is inversely related to organizational loyalty add to the complexity of the mental health administrator's task. In a study of 120 CMHCs, for example, Jones, et al concluded that the staff members in the centers viewed agency policy as expendable to professional standards.

Third, the transaction between the therapist and patient is highly private and intimate in mental health -- must more so than in most other fields. As a result, it is very difficult for the organization to collaborate with or intrude into the process, even when warranted. It is not unusual for the patient and therapist to enter into an alliance, not always conscious, in which the organization is viewed as the enemy, particularly regarding such unpleasantries as fee charging and decisions to terminate treatment.

Fourth, in mental health, we are frequently dealing with a highly dependent patient population and this presents extraordinary problems for the administrator and the staff in maintaining a responsive, accountable and humane program. The recurrent public scandals in some of our State mental hospitals and institutions for the retarded are unhappy reminders of these problems.

Fifth, our product is highly intangible and our criteria of success are very difficult to determine and to measure. The terrain is littered with ill-conceived and executed evaluation studies and the technology of evaluation in mental health remains quite limited. It is, therefore, very difficult for the mental health administrator to evaluate the effectiveness of the organization, or even of individual staff members for that matter. These difficulties also exist for outside groups and organizations attempting to evaluate the utility of mental health agencies. As a result, I suspect that at least some of these agencies survive, and even grow, long after they have stopped being of value to anyone.

Sixth, the boundaries of mental health services are very difficult to define as exemplified by the now too familiar and tiresome debate in community mental health between advocates of the "medical" model and those of the "social" model. While this ambivalence about boundaries and objectives has some obvious advantages, particularly for the administrator who wishes to avoid accountability, it permits the mental health organization to be seen as the vehicle for meeting a wide variety of frequently divergent needs and encourages unreal expectations. It is those expectations that have accounted for some of the well publicized conflicts in our community mental health programs.

Seventh, the public image of mental health services, the enduring stigma that is associated with their use and the problems of

confidentiality add a significant complicating factor to the administrative task in the mental health field.

And last, somewhat less tangible but perhaps most important, is the need for a mental health organization to communicate hope and confidence to the people using its services. As Whittington has written, "While a surgeon may perform an operation with high technical competence even though he feels that the leader of his program is autocratic, arbitrary and derogates his importance, the mental health practitioner can rarely function with optimal efficiency if he has similar feelings about the leader. In every transaction with a patient, the management of a mental health center is an invisible, but by no means silent partner[1]."

It seems rather obvious that these characteristics that make administrative tasks in mental health administration distinctive are also true of the fields of mental retardation and DD administration.

VARIOUS OPTIONS OF DEGREE AWARDING PROGRAMS

There was some discussion at the Denver meeting given to the possibility of an external degree. This, however, deals primarily with the current administrator who needs to upgrade his skills while still continuing his present managerial position. Since this fits more in the line of continuing education, this point will be spoken to in the report on continuing education.

There were four different graduate programs represented at the Denver meeting. All were housed in different areas of universities

and all had somewhat a different philosophical base. It was felt that this was not bad at all because if all were doing exactly the same thing with the same structure, there would be very little creativity and program advancement. All programs, however, have the capability to teach the basic generic administration and managerial skills.

Data from the questionnaire results can be used in terms of deciding what content should go into the formal academic programs. Therefore, about all that can be added to this section is to reiterate that there are a number of avenues for a student desiring to go into health services administration to pursue the basic generic educational preparation. Different approaches should be tried and experimented with.

BASIC CURRICULUM DEVELOPMENT

There was some very lively and interesting discussion concerning curriculum development at the Denver committee meeting. The essence of some of that discussion follows, since it gives an insight into how the authors arrived at some of their recommendations.

An important concept brought out was that one of the real fundamental issues of our thinking was that management is the only field where a person is educated to go into a role that he is not going to fill as soon as he gets out of school. If you are educating yourself to become a social worker, you know what your first job is going to be like. On the other hand, those in management are theoretically trained to be a top executive, but in reality will more likely enter into a second or third level management position. This person has to be experienced in the particular field in which he is working before he is

theoretically capable of assuming a top management position. The importance of having a good solid background in such things as financial management and budgeting was stressed. This kind of course work in school and the realities of budgeting and financial management in an actual position are somewhat disimilar. Most of the practical issues have to be learned on the job and cannot be learned in an academic setting.

One of the areas that is distinctive to this field and should be included in a curriculum for a DD or an MR graduate is the importance of moving these programs into the communities. Community centers have evolved along two different lines. One is very close to the community health model where they find themselves as providers of services at the community level. The other is where the community center is essentially a purchaser of services or a case manager. If a person were being trained to go into one of the case management type programs to administer a regional center, there is a lot in the health administrator background that would be beneficial to him. However, unless he is also acquainted with some of the broader components relative to other systems, it will be very difficult for him to administer such a program. Consideration has to be given to including aspects of these other programs in a curriculum. Such an administrator has to be able to pull together all these different types of functions and know how to deal with them. However, it is questionable whether you can build that capacity for dealing with them in the context of an academic setting. You can build in the capacity by dealing with certain generic kinds of management decisions, but it would appear that the capacity to deal with other areas has to come with the sophistication that comes with experience.

There was some dialogue in the Denver meeting, but very few concrete results about the characteristics a student should have after he finishes at least one year in a graudate health care administration program.

QUESTIONNAIRE RESULTS

INTRODUCTION

The evolution of decision making theory in the past decade has taken a definite trend toward the quantitative, operations-research and management science approaches, with a secondary orientation to organizational decision behavior. The effects of these trends have raised a number of interesting questions related to the operations and management of multi-discipline health-related organizations as well as questions related to the education of health service administrators.

These problems have long been of interest to UAF and other health-related administrators. The need to review current health service related training programs and to suggest possible curriculum adjustments was discussed in some detail at the UAF Management Improvement Workshop in New Orleans in November of 1973.

In order to help identify the major functional areas of responsibilities for administrators, six different groups related to health services administration were requested to complete and return the questionnaire developed by the UAF administrator's training project planning committee.[4] The questionnaire requested demographic data from each participant and his organization as well as his educated opinion about competencies in 10 major management areas with 59 sub-areas. The questionnaire was mailed to the following six groups: (1) Directors -

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4 A copy of the questionnaire and a complete tabulation of the results are presented in Appendix A.

UAF and MR centers, (2) Administrators - UAF and MR centers, (3) Coordinators - state programs of MR, (4) Governmental staff, (5) Graduate school health program directors and (6) Community developmental disabilities directors. These groups represented a wide range of persons interested in health services administration who are at different organizational levels and who have different functions. The questionnaire was mailed to 316 individuals and 170 questionnaires were returned completed for a 54 percent return rate.

DEMOGRAPHIC DATA

Each person responding to the questionnaire was requested to provide some limited personal and organizational data. The personal data requested included information on educational background, administrative experience and age. The organizational data requested included information on organizational base, size of organization, operating budget and manpower status.

Personal Data

From the personal data collected and shown in chart form in Appendix A, pages 78-79, under Academic Background, Administrative Experience and Age, one can make the following generalizations about the groups who completed the questionnaire:

Academic Background[5]

- 88% of the directors hold the doctoral degree (44% MD, 33% PhD, 11% EdD and 11% hold the masters degree).

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[5] Some totals do not equal 100% because of some missed data.

- 60% of the administrators hold the masters degree, 13% hold the doctoral degree and 27% hold the bachelor degree.
- 31% of the coordinators of state MR programs hold the doctoral degree, 58% hold the masters degree, and 8% hold the bachelor degree.
- 69% of the governmental staff hold the masters degree and 19% hold the doctoral degree.
- 79% of the graduate school program faculty hold the doctoral degree and 13% hold the masters degree.
- 60% of the community developmental disabilities directors hold the masters degree, 27% hold the doctoral degree and 11% hold the bachelor degree.

Administrative Experience

The questionnaire results indicated that a high percent of all groups had more than 5 years of administrative experience. The data revealed that 93% of all directors had more than 5 years administrative experience as did 77% of the administrators, 80% of the coordinators-state program directors of MR, 94% of the governmental staff, 83% of the graduate school program directors and 64% of the community developmental disabilities directors.

Age

The age for all six groups ranged from 26 to 64 with the average age per group as follows: directors - 47, administrators - 42, coordinators - state programs of MR - 41, governmental staff - 50,

graduate school program directors - 41, and community developmental disabilities directors - 39.

From these personal data we were able to obtain information from a representative group of individuals who are interested and concerned about health services administration. These data were extremely valuable in analyzing the responses to the substantive section of the questionnaire.

Organizational Characteristics

From the organizational data collected and shown in chart form in Appendix A, (under Organizational Base, Staff Members, Clients Served Per Year, Operating Budget and Administrative Manpower) one can make the following generalizations about the organizations represented in the survey.

Organizational Base

The questionnaire results indicated that 71% of the UAF and MR research centers are located at public universities along with 65% of the graduate programs in health administration. As expected, the organizational base for state programs in MR and community developmental disabilities programs are primarily based at the state level.

Staff Size

The survey also indicated that more than 40,000 individuals are currently employed in the various institutions. Of this number, 11,942 are classified as professional and 28,354 as supporting personnel. This provides a professional to support ratio of 1:2.37.

Clients Served

The clients served per year by the institutions surveyed range from less than 100 to more than 5,000. The data indicated that 40% to 50% of the institutions serve from 500 to 1,500 clients per year.

Operating Budget

The operating budgets for the institutions surveyed ranged from less than $250,000 per year to more than $5,000,000 per year. Approximately 50% of these institutions have an operating budget between $500,000 and $3,000,000 per year.

Administrative Manpower

The survey also indicated that there are 5,694 administrative positions in the current structure of the institutions surveyed. Of this number, 619 are at the doctoral level, 1,248 are at the masters level and 3,827 are at the bachelors level. These institutions are also projecting an increase in the number of new administrative positions in the next three years. They are projecting 386 new administrative positions, 67 will be at the doctoral level, 167 at the masters degree level and 152 at the bachelors degree level.

From this organizational data it appears that we were able to obtain information from a wide variety of organizations concerned with health care administration. Theoretically, this should help make the substantive sections of our position paper more valid and helpful in planning for curriculum change.

RESPONSIBILITIES FOR ADMINISTRATORS

The six different groups previously described were requested to respond to 59 major functional areas of management systems on a Likert Scale of 1 to 5. Each person was requested to indicate the degree of involvement for administrators in each of the 59 areas. From this data, it can be inferred what role and to what degree an administrator should be involved with the major functional areas of management for health services related programs.

Analysis of variance with multiple groups was run on each of the 59 items for each group. From these analyses, group means were calculated along with the P-value. (The complete analysis of variance for each item is shown in Appendix A, pages 84-89. P-values below the 0.05 level indicate significant group mean differences.) Out of the 59 items analyzed, only 14 had a P-value of less than 0.05. This indicates a high degree of similarity in the group responses. While it is difficult to pinpoint any major trends, a few general observations can be made from these data. In general it can be said that directors, administrators and governmental staff tend to respond in similar patterns to the 59 items, and coordinators of state programs, graduate school directors and community developmental disabilities directors tend to cluster together. Administrators tend to rank items slightly higher than did other groups. Coordinators of state MR programs and community developmental disabilities directors tend to rank the need for supporting systems lower than other groups. This may indicate their reliance upon existing supporting systems located in the state government or community levels.

In order to simplify data presentation, the 59 areas were grouped into 10 major management areas and group means were calculated for each area along with the rank order by groups. These data are shown in Exhibit 2, page 52.

The group mean for all groups shown in Exhibit 2 ranged from a low of 2.95 to a high of 4.48 on the Likert Scale. These relatively high scores indicate a strong preference for each of the major management areas listed in Exhibit 2. The rank order for each major management area shows that each group places emphasis on different managerial functions, but that the relatively high mean scores indicate a strong preference for all 10 management areas.

There are a number of interesting analyses and conclusions that can be drawn from the results of this questionnaire. The authors feel, however, that this position paper is not the appropriate place for these detailed analyses to be made. The questionnaire results, however, can and should be used by UAFs to recommend (to graduate programs in health administration) the areas that should be included in a basic curriculum for educating MR and DD administrators. The areas of responsibilities listed in the questionnaire results, along with the list of topical areas in the recommendations and conclusions section, can be used as a planning document for developing future program curricula.

EXHIBIT 2

GROUP MEANS AND RANK ORDER

	Directors		Admin.		Coord. State Prog.		Gov't. Staff		Grad. Prog. Directors		Commun. D. D. Dirs.	
	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank
Principles of Organization and Management	4.08	3	4.39	5	4.34	1	4.45	1	4.43	1	4.41	1
Organizational Development	3.88	7	4.32	7	3.70	6	4.00	4	3.83	5	3.85	6
Personnel Systems	3.91	6	4.35	6	3.39	8	3.74	7	3.21	10	3.59	9
Direction and Communication	3.80	9	4.01	9	3.94	3	3.75	6	3.98	4	4.04	3
Controlling-Operations	3.94	5	4.48	1	3.50	7	3.78	5	3.69	6	3.76	7
Financial Development and Accounting	4.15	1	4.45	2	2.95	10	3.46	10	3.42	8	3.49	10
Economics and Cost Analysis	3.82	8	4.30	8	3.23	9	3.66	9	3.30	9	3.70	8
External Organizational Relationship	3.70	10	4.05	10	3.85	5	3.69	8	3.68	7	3.88	5
Management Information System	4.11	2	4.41	4	3.97	2	4.31	2	4.06	2	4.21	2
Health Care Delivery System	4.00	4	4.44	3	3.93	4	4.02	3	3.99	3	4.03	4

RECOMMENDATIONS AND CONCLUSIONS

INTRODUCTION

This position paper has thus far reviewed a number of issues and considerations that speak to the graduate education of administrators for Mental Retardation and Developmental Disability programs and facilities. The recommendations, with supporting information based upon these issues are divided into two sections. The first section consists of three recommendations that necessitate actions by agencies and individuals external to UAFs in order to implement them. They are more global and long-range in nature than the other recommendations. Implementation of the five recommendations in the second section is dependent upon cooperative arrangements between UAF administrators and Directors of Graduate Programs in Health Administration. They do not require coordination or support from other agencies in order to initiate them.

SECTION ONE

RECOMMENDATION #1

That a manpower study be undertaken to ascertain the number and type of educated administrators that will be needed in the fields of mental retardation and developmental disabilities for the next 5, 10, 15 and 20 years.

There have been numerous estimates of the number of trained administrators that will be needed in the fields of mental retardation and developmental disabilities in the coming years. It would be a rela-

tively simple task for the authors to present their own recommendations based upon the results of our questionnaire. However, all of these would be rough estimates based upon very little factual information. It is essential that those designing graduate programs for administrators in these specialty fields have at their disposal an accurate body of information concerning the need for administrators in the coming years.

RECOMMENDATION #2

That lines of communication and working relationships be developed between the Association of University Programs in Health Administration and the American Association of University Affiliated Programs to facilitate working relationships between individual graduate programs in health administration and UAFs.

The Association of University Programs in Health Administration (AUPHA) is a professional organization that grew out of the need on the part of graduate programs in hospital administration 25 or 30 years ago to band together to share common problems. Essentially the program is based on curriculum development for University programs. Its primary activities are in task forces. These spin out into some research projects, a couple of which are now going on are appropriate to this field. There are some other activities of AUPHA that fall into the area of logistic support. It is an organization that is going through a major growth period and changing its orientation. Although in the past the organization was primarily institution oriented, it is changing

to meet the needs of new interests and focus. The Task Force on Mental Health and Mental Retardation Administration is one example of this new effort.

There are currently 38 graduate programs that belong to the AUPHA. All of these programs are full members of the association. There are three other categories of membership: 1) associate, either in transition to full membership or undergraduate programs, 2) associate members for foreign purposes and 3) individual memberships.

The accreditation of these graduate programs was formerly carried out by the AUPHA, but is now carried out by a separate commission, The Accrediting Commission on Graduate Education for Health Administration. This commission is composed of representatives from the AUPHA, American Public Health Association, American Hospital Association and American College of Hospital Administrators. The commission membership is currently being expanded. In the future someone will represent planning interests through the American Association of Comprehensive Health Planners, the Nursing Home Administrator College, ambulatory care represented by the clinic manager's group and mental health administration through the Association of Mental Health Administrators.

Since the AUPHA is fast changing to meet the needs of an expanding health administration field, close working relationships with it are essential.

RECOMMENDATION #3

That multiple sources of funding be investigated and promoted by the AAUAP and individual administrators to finance the development of graduate program education for administrators of MR/DD facilities and programs.

The questions of funding for this whole area is a crucial one. The minimal support that has been given so far to develop this position paper and the management improvement workshop has come from the University Programs Section, Division of Health Services Training, Bureau of Community Health Services, Health Services Administration. They do not have the capability to support full time faculty unless that was one of the top priorities of a particular UAF. They do have the capability of supporting stipends for traineeships in administration in a particular UAF. Again, that support must fit in with the overall priorities of the individual UAF and would usually involve shifting the use of existing funds. The amount of money that they would have available for this purpose is very limited.

The other major potential source of funding would be through the Developmental Disabilities Office in the Office of Human Development. The Developmental Disabilities Act at one time contained a provision for funds for training of administrators. However, this was dropped from the legislation.

The President's Committee on Mental Retardation, although not a funding agency, can serve as a supporting organization to legislate financial support for administrative training programs.

SECTION TWO

RECOMMENDATION #1

That this position paper be presented to the Task Force on Mental Health and Mental Retardation Administration for their consideration and that administrators of UAFs work together with the Task Force to develop a curriculum which will be applicable to both mental health administration and mental retardation/ developmental disabilities administration.

Because of the similarities in administration of mental health and MR/DD programs and institutions it is desirable to have the efforts of the UAF administrator's training project dovetail with those of the Task Force on Mental Health and Mental Retardation Administration.

The results of the questionnaire found in Appendix A contain some of the basic curriculum areas that should be included in a generic administration graduate program. The authors, of course, realize that the exact curriculum format will differ depending upon the particular graduate program in which the student is enrolled. At the Denver meeting a laundry list of subject areas was developed that we feel should be included in a graduate program curriculum. These were as follows:

- Problem Solving
- Planning
- Organization
  - Structure
  - Relationship
- Financial Management
  - Budget conceptualization
    - Formulation
    - Justification
  - Cost Analysis and Forecasting
  - Expenditure Monitoring
  - Funding
- Client Characteristics
- Intervention Modalities

Service System Characteristics
Multi-functioning/Multi-discipline
Use of generic agencies
Advocate/Legal rights/ parents-consumers, ethical issues
Public Personnel Systems
Public Education & Information

This list and the competencies listed in the questionnaire results can serve as input to the Task Force on Mental Health and Mental Retardation Administration. The Task Force should consider what type of person a mental health, mental retardation or developmental disability administrator should be. What type of areas should this person be skilled in? What type of attitudes should this person possess? With such a descriptive picture of what an administrator should be, it would then be important to suggest a series of models of curriculum the Task Force feels would produce this type of person.

There was some discussion at the Denver meeting as to whether all of this exercise on curriculum development was necessary. It was felt that all parties need to be involved in this exercise and that it is a necessary step. Five years from now we may discover that the best way to handle this whole thing is through individualized practicum. However, at this point curriculum development seems to be at least a necessary stage through which we must go.

RECOMMENDATION #2

That individuals who wish to go into entry level administrative positions in the fields of mental retardation or developmental

disability programs and institutions be directed to graduate programs in health administration which have developed academic affiliations with University Affiliated Facilities.

The main concern the authors have for a student going into a graduate program is that this person be able to develop the competencies to become an effective administrator. The existing graduate programs in health administration are more likely to have an existing structure which can provide this but we are not ruling out programs outside of health administration. Most of the existing graduate programs in health administration already have the basic generic curriculum in administration which we feel is important.

RECOMMENDATION #3

That University Affiliated Facility administrators develop working relationships with individual graduate programs in health administration to develop the practicum portion of a student's education in administration.

The UAFs can provide an excellent opportunity for graduate programs in health administration to link up with a training concept that is multi-faceted and will look at things from a multi-dimensional point of view. If a student serves an administrative residency in a UAF, he is not necessarily being trained to become a UAF administrator. Instead, the authors are talking about a training focus or situation where a student can be involved in a lot of activity that relates to the

type of functions he will be responsible for managing after his graduation.

Because UAFs are very much involved with agencies and other activities in the community in terms of referrals back and forth and in terms of various kinds of continuing education of consultants, they are in and of themselves marvelous training programs. Their involvement with the community and its agencies would offer the practicum student the opportunity to spend part of his practicum in some of the community agencies that the UAFs are affiliated with.

Since very few individuals are aware of this administrative training potential in UAFs, it is necessary for UAFs to make the approach to a given graduate program in health administration for the purpose of developing a training relationship. With the information available in this position paper and the questionnaire results, it is feasible for UAF administrators and directors to facilitate a formal interface with graduate program faculty to bring that data together into some kind of a matrix in terms of the kind of information which administrators ought to have. They can then sit down together and define the practicum and kinds of experiences which UAFs can provide and which the administrative student should face.

RECOMMENDATION #4

That UAFs play an active role in the recruitment and selection of students in the specialty areas of mental retardation and developmental disability administration.

It is very difficult to describe the type of people who should be

selected for entry into these specialty areas in health care administration or any other areas. What should we look for in a student? What experience, if any, should he have? What exposure to the field, intelligence, etc., is necessary. This is an area in which much research needs to be done.

Since in this position paper we are talking about the student who is going into an entry level position, student selection is a crucial element. Although a laundry list of some sort could be developed, the essential point is that a representative of the UAFs in the person of the administrator should have the capability of providing input to an admission screening committee.

Another real problem is the appeal which the mental health and mental retardation fields have to students coming into these areas. The "nice shiny hospital on the hill" has much more appeal to a student coming into this type of program than our fields, which have a very low image as far as the overall health care administration field is concerned. Unless we have some type of involvement and can guide the student prior to his entering graduate school or during the first year of his generic administrative education, it will be difficult to get a committment from the student to enter the field of mental retardation or developmental disability administration.

One possibility is based upon a model of what is being done to recruit minority students. Between the junior and senior year of undergraduate work, summer jobs can be constructed in which people are brought in and put through an orientation as to what goes on in a UAF. This could be orchestrated in a weekly seminar.

One of the major elements to consider for admitting a student in this area would be to look for students who have had some work experience in this field or a related field and can demonstrate that they have some potential and would be able to do the job once they are finished with their education.

The Task Force on Mental Health and Mental Retardation Administration recently addressed the question of what might be looked for in a student. They discovered that he can come from a variety of backgrounds and has no particular personality characteristics except the potential for success in their field of training.

RECOMMENDATION #5

That UAF administrators hold a faculty appointment in the graduate program in which they develop an affiliation.

It is essential that the administrator have a faculty appointment which follows the pattern of all other training in the UAFs. This way he or she can represent the department which they happen to be affiliated with and can be influential in changes of curriculum, etc. If he does not sit on the faculty council, it's difficult to put any change in the curriculum and make it relevant to the MR/DD field.

The practicality of combining into one position the academic side of the UAF program and the operating end of it is very limited. It is not always feasible for the administrator who is responsible for management programs to also have to undertake the teaching workload involved with a formal faculty appointment. The idea of hiring a faculty member to carry the major load of this teaching responsibility is one alternative. Although there is very little inconsistency between teaching and managing,

the time element may make it impractical. The other way of approaching this problem is to hire an administrative assistant to do most of the routine work to allow the administrator to do more in the teaching area. The point is that the administrator may well have to make a choice as to whether his primary responsibility will be that of teaching or the day to day management operations.

Another real problem is that most of the current UAF administrators have not obtained the highest academic degree available in their field and, therefore, would not be considered for full faculty appointment to a number of graduate programs. Although it is not necessary in some schools for faculty to obtain the highest degree available, in most this is a real requirement. This is a point that would have to be overcome by individual negotiations between UAFs and graduate programs. The basic principle, however, would be that the administrator faculty member's appointment should have prestige at least equal with any other faculty member within that particular university setting.

It would be desirous to develop a wide variety of working relationships between UAFs and graduate programs and to evaluate their effectiveness. Loose types of arrangements with no formal faculty appointments in the graduate programs would be less influential with the Association of University Programs in Health Administration and their constituents and also less influential with other accredited graduate programs in health care administration. A close working relationship with formal academic appointments and the development of specified kinds of programs where it is possible to have on-going relationships, task forces, and section meetings at AUPHA, would be more effective.

SUMMARY

Overall coordination with the Task Force on Mental Health and Mental Retardation Administration and AUPHA will certainly be helpful in developing programs for educating administrators to go into the MR/DD fields. However, the only way a program is going to be made to work is through organizational arrangements between a particular UAF and a particular gradua' ram. They will have to work out mechanisms for getting students into their program and for placing students when they graduate into an appropriate position.

In summary, there are four basic considerations in setting up working relationships between UAFs and graduate programs in health administration.

1. The practicum or administrative residency, whatever it is called, is the mutual meeting point.
2. A series of activities in the area of student recruitment is essential.
3. Establishment of formal relationships between AAUAP and AUPHA.
4. To use these formal relationships as well as faculty appointments as a mechanism for avoiding some of the problems that have occurred before between operators and educators.

APPENDIX A

RESULTS

HEALTH SERVICES ADMINISTRATOR EDUCATION

QUESTIONNAIRE

For Data Processing Only

HEALTH SERVICES ADMINISTRATOR EDUCATION QUESTIONNAIRE

I. DEMOGRAPHIC DATA (Please check the following items that best describes your position and organization.)

A. Position (Please check only one.)

1-Program Director ( )

2-Administrative Director ( )

3-Teaching Faculty ( )

4-Federal Governmental Program Staff ( )

5-State Governmental Program Staff ( )

6-Local Governmental Program Staff ( )

B. Educational Background (Check highest degree.)

1-BA/BS ( ) 4-LLB/JD ( )

2-MS/MA ( ) 5-PhD ( )

3-EdD ( ) 6-MD ( )

Major Discipline:_____

C. Administrative Background (Check the one area below that best describes your current role.)

1-Organization Administration ( )

2-Program Administration ( )

3-Supervisor of Administrative Support Services ( )

4-Administrative Assistant ( )

5-Teaching Faculty ( )

6-Other (Please specify)_____ ( )

D. Administrative Experience (Please check only one.) □

1-Less than 1 year ( )

2-1 to 2 years ( )

3-2 to 3 years ( )

4-3 to 4 years ( )

5-4 to 5 years ( )

6-More than 5 years ( )

E. Age (Please indicate your age in years.) □□

Age: _____

F. Organizational Base (Please check only one.) □

1-University-Public ( )

2-University-Private ( )

3-Nonprofit Public ( )

4-Nonprofit Private ( )

5-Federal Government ( )

6-State Government ( )

7-Local Government ( )

G. Number of Employees in Your Program (Not applicable for teaching faculty and Federal governmental program staff.)

1-Professional Personnel _____ □□□□

2-Support Personnel _____ □□□□

H. Number of Clients Served by Your Program Annually (Please check only one. Not applicable for teaching faculty and Federal governmental program staff.) □□

1-Less than 100 ( )

2-101 to 200 ( )

3-201 to 300 ( )

4-301 to 400 ( )

5-401 to 500 ( )

6-501 to 1000 ( )

7-1001 to 1500 ( )

8-1501 to 2000 ( )

9-2001 to 2500 ( )

10-2501 to 5000 ( )

11-More than 5000 ( )

I. Operating Budget - Current Year (Please check only one. Not applicable for teaching faculty and Federal governmental program staff.) ☐☐

1-Less than $250,000 ( )
2-251,000 to 300,000 ( )
3-301,000 to 350,000 ( )
4-351,000 to 400,000 ( )
5-401,000 to 450,000 ( )
6-451,000 to 500,000 ( )
7-501,000 to 1,000,000 ( )
8-751,000 to 1,000,000 ( )
9-1,000,001 to 1,500,000 ( )
10-$1,500,001 to 2,000,000 ( )
11-2,000,001 to 2,500,000 ( )
12-2,500,001 to 3,000,000 ( )
13-3,000,001 to 3,500,000 ( )
14-3,500,001 to 4,000,000 ( )
15-4,000,001 to 4,500,000 ( )
16-4,500,001 to 5,000,000 ( )
17-More than 5,000,000 ( )

II. HEALTH SERVICES ADMINISTRATION MANPOWER AND STATUS NEEDS

A. How many administrative positions do you currently have in your organization that require a doctorate? _____ ☐☐

B. How many administrative positions do you currently have in your organization that require a masters degree? _____ ☐☐

C. How many administrative positions do you currently have in your organization that require a bachelors degree? _____ ☐☐

D. Does your program plan to increase the number of administrative positions in the next 2-5 years? ☐

1-Yes ( )
2-No ( )
3-Do not know ( )

E. If yes to the above question:

How many bachelor positions? _____ ☐☐
How many masters positions? _____ ☐☐
How many doctoral positions? _____ ☐☐

III. RESPONSIBILITIES FOR ADMINISTRATORS. In this section of the questionnaire we are trying to determine what role and degree the administrator should play in the major functional areas of management for health services programs. Please circle the number that represents the degree to which you feel an administrator should be involved in the major functional areas of management systems that are listed below.

A. Principles of Organization and Management

1) Organizational Planning

1 Never 2 3 Sometimes 4 5 Always

2) Program Planning

1 Never 2 3 Sometimes 4 5 Always

3) Decision Making

1 Never 2 3 Sometimes 4 5 Always

4) Policy Making

1 Never 2 3 Sometimes 4 5 Always

B. Organizational Development

1) Nature and Purpose of Organization

1 Never 2 3 Sometimes 4 5 Always

2) Scope of Management Authority

1 Never 2 3 Sometimes 4 5 Always

3) Assignment of Activities

1 Never 2 3 Sometimes 4 5 Always

4) Determination of Line-Staff Relationships

1 Never 2 3 Sometimes 4 5 Always

5) Provision of Support Services

1 Never 2 3 Sometimes 4 5 Always

6) Structuring of Committees

1 Never 2 3 Sometimes 4 5 Always ☐

C. Personnel

1) Personnel Administration

1 Never 2 3 Sometimes 4 5 Always ☐

2) Recruitment Procedures

1 Never 2 3 Sometimes 4 5 Always ☐

3) Supervision and Training

1 Never 2 3 Sometimes 4 5 Always ☐

4) Performance Evaluation and Promotions

1 Never 2 3 Sometimes 4 5 Always ☐

5) Employer-Employee Relationship

1 Never 2 3 Sometimes 4 5 Always ☐

D. Direction and Communication

1) Communication of Organizational Goals

1 Never 2 3 Sometimes 4 5 Always ☐

2) Facilitate Communication within the Organization (Formal and Informal)

1 Never 2 3 Sometimes 4 5 Always ☐

3) Communication with the Media

1 Never 2 3 Sometimes 4 5 Always ☐

4) Public Relations Communication

1 Never 2 3 Sometimes 4 5 Always ☐

5) Leadership within the Organization

1 Never 2 3 Sometimes 4 5 Always ☐

6) Leadership Outside the Organization

1 Never 2 3 Sometimes 4 5 Always ☐

E. Controlling

1) Program Operations

1 Never 2 3 Sometimes 4 5 Always ☐

2) Organizational Operations

1 Never 2 3 Sometimes 4 5 Always ☐

3) Policies Development

1 Never 2 3 Sometimes 4 5 Always ☐

4) Support Systems

1 Never 2 3 Sometimes 4 5 Always ☐

5) Personnel System

1 Never 2 3 Sometimes 4 5 Always ☐

6) Financial System

1 Never 2 3 Sometimes 4 5 Always ☐

F. Financial Development and Accounting

1) Basic Organizational Budgeting

1 Never 2 3 Sometimes 4 5 Always ☐

2) Program Budgeting

1 Never 2 3 Sometimes 4 5 Always ☐

3) Basic Organizational Accounting

1 2 3 4 5
Never Sometimes Always ☐

4) Individual Program Accounting

1 2 3 4 5
Never Sometimes Always ☐

5) Funds Development - Federal Government

1 2 3 4 5
Never Sometimes Always ☐

6) Funds Development - State Government

1 2 3 4 5
Never Sometimes Always ☐

7) Funds Development - Local Government

1 2 3 4 5
Never Sometimes Always ☐

8) Funds Development - Labor and Industry

1 2 3 4 5
Never Sometimes Always ☐

9) Third Party Payment

1 2 3 4 5
Never Sometimes Always ☐

10) User Fees Development/Collection

1 2 3 4 5
Never Sometimes Always ☐

11) Philanthropy

1 2 3 4 5
Never Sometimes Always ☐

G. Economics and Cost Analysis

1) Cost Benefit Analysis

1 2 3 4 5
Never Sometimes Always ☐

2) Manpower Development

1 2 3 4 5 ☐
Never Sometimes Always

3) Impact of Economic Factors on the Supply of Developmental Disabilities Services

1 2 3 4 5 ☐
Never Sometimes Always

4) Relationship between Economic Status and Need for Developmental Disabilities Services

1 2 3 4 5 ☐
Never Sometimes Always

H. External Organizational Relationships

1) Program Relationships with Federal Government

1 2 3 4 5 ☐
Never Sometimes Always

2) Program Relationships with State Government

1 2 3 4 5 ☐
Never Sometimes Always

3) Program Relationships with Local Government

1 2 3 4 5 ☐
Never Sometimes Always

4) Program Relationships with Other Agencies

1 2 3 4 5 ☐
Never Sometimes Always

5) Departmental Relationships within the Parent Organization

1 2 3 4 5 ☐
Never Sometimes Always

6) Legal Implications Related to Developmental Disabilities Services

1 2 3 4 5 ☐
Never Sometimes Always

7) Political Matters Related to Developmental Disabilities Services

1 2 3 4 5 ☐
Never Sometimes Always

I. Management Information System

1) Development of Record Systems

1 2 3 4 5
Never Sometimes Always

2) Development of Policy on the Use and Abuse of Confidential Information

1 2 3 4 5
Never Sometimes Always

3) Computer and Technology of Information

1 2 3 4 5
Never Sometimes Always

4) Operational Responsibility of Data Processing Systems

1 2 3 4 5
Never Sometimes Always

J. Health Care Delivery Systems

1) Integration of Developmental Disabilities Program with Community

1 2 3 4 5
Never Sometimes Always

2) Liaison Relationship with Community Health Agencies

1 2 3 4 5
Never Sometimes Always

3) Represents the Organization or Program to the Community

1 2 3 4 5
Never Sometimes Always

4) Determines and Identifies Community Needs

1 2 3 4 5
Never Sometimes Always

5) Determines Community Resources for Developmental Disabilities Services

1 2 3 4 5
Never Sometimes Always

6) Determines Types and Extent of Evaluation Services for Developmental Disabilities

1 2 3 4 5
Never Sometimes Always

Please add additional topic areas that you think an administrator should play and indicate the degree on a scale of 1 - 5.

Area: _____

1	2	3	4	5
Never		Sometimes		Always

Area: _____

1	2	3	4	5
Never		Sometimes		Always

Area: _____

1	2	3	4	5
Never		Sometimes		Alwyas

Your assistance in completing this questionnaire is greatly appreciated and will be very helpful in determining the basis for a curriculum program in multidiscipline health services administration.

QUESTIONNAIRE RESPONSE SUMMARY

Groups	# Mailed	# Received	% Returned
Directors - UAF & MR Centers	50	27	54
Administrators - UAF & MR Centers	47	30	64
Coordinators State Programs of MR	53	26	49
Governmental Staff	22	16	73
Graduate Program Directors	38	24	63
Community D. D. Directors	106	47	44
TOTAL	316	170	54

DEMOGRAPHIC DATA

I. Group Characteristics

A. Academic Background

Groups	# Responding	BA/BS #	BA/BS %	MS/MA #	MS/MA %	EdD #	EdD %	PhD #	PhD %	MD #	MD %
Directors - UAF & MR Centers	27			4	14	3	11	9	33	12	44
Administrators - UAF & MR Centers	30	8	27	18	60	1	3	2	7	1	3
Coordinators State Programs of MR	26	2	8	15	58			7	27	1	4
Governmental Staff	16			11	69			3	19		
Graduate Program Directors	23	1	4	3	13			16	70	2	9
Community D. D. Directors	47	5	11	28	60	4	8	4	8	5	11
TOTAL	169*	16	9	79	47	8	5	41	24	21	12

* One person indicated no degree.

B. Administrative Experience

Groups	Years <1 #	<1 %	1-2 #	1-2 %	2-3 #	2-3 %	3-4 #	3-4 %	4-5 #	4-5 %	>5 #	>5 %
Directors - UAF & MR Centers							2	7			25	93
Administrators - UAF & MR Centers			1	3	3	10			3	10	23	77
Coordinators State Programs of MR	1	4	1	4			1	4	2	8	21	80
Governmental Staff									1	6	15	94
Graduate Program Directors					1	4	1	4	2	9	19	83
Community D. D. Directors	1	2	3	6	6	13	4	9	3	6	30	64
TOTAL	2	1	5	3	10	6	8	5	11	6	133	79

C. Age

Groups	Years $\bar{X}$	Range
Directors - UAF & MR Centers	47	30-59
Administrators - UAF & MR Centers	42	29-64
Coordinators State Programs of MR	41	28-58
Governmental Staff	50	31-59
Graduate Program Directors	41	27-64
Community D. D. Directors	39	26-56

II. Organizational Characteristics

A. Organizational Base

Groups	Univ. Public #	Univ. Public %	Univ. Private #	Univ. Private %	Non-Profit Public #	Non-Profit Public %	Non-Profit Private #	Non-Profit Private %	Federal Gov't. #	Federal Gov't. %	State Gov't. #	State Gov't. %	Local Gov't. #	Local Gov't. %
Directors - UAF & MR Centers	19	71	6	22							2	7		
Administrators - UAF & MR Centers	24	80	4	13	1	3			1	3				
Coordinators State Programs of MR							1	4			25	96		
Governmental Staff									16	100				
Graduate Program Directors	15	65	7	31							1	4		
Community D. D. Directors			2	6	4	8	9	19			33	72	1	2
TOTAL	58	34	20	12	5	3	10	6	17	10	60	36	1	1

B. Staff Members

Groups	Professional #	Professional %	Support #	Support %	Total	Ratio Prof:Supp.
Directors - UAF & MR Centers	1,664	45	2,012	55	3,676	1:1.21
Coordinators State Programs of MR	6,250	24	19,743	76	25,993	1:3.16
Governmental Staff	95	46	110	54	205	1:1.16
Graduate Program Directors	1,320	71	545	29	1,865	2.42:1
Community D. D. Directors	2,613	31	5,944	69	8,557	1:2.28
TOTAL	11,942	30	28,354	70	40,296	1:2.37

C. Clients Served Per Year

Groups	<100		101-200		201-300		301-400		401-500		501-1000		1001-1500		1501-2000		2001-2500		2501-5000		>5000	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Directors - UAF & MR Centers	1	4	3	13	2	9	1	4			8	35	1	4	2	9			3	13	2	9
Administrators - UAF & MR Centers			3	10	3	10	1	3	1	3	7	23	5	17	4	14			3	10	3	10
Coordinators State Programs of MR	1	4	1	4	2	8					1	4			2	8	3	12	4	16	11	44
Community D. D. Directors	4	9	9	20	4	9	3	6	4	9	5	11	3	6	3	6	3	6	2	4	6	13

D. Operating Budget

Groups	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Directors - UAF & MR Centers	4	16	2	8									3	12	1	4	3	12	5	20	1	4	2	8			1	4			1	4	2	8
Administrators - UAF & MR Centers	1	3	2	7									3	10	2	7	3	10	6	20	2	7	2	7	1	3	2	7	1	3	1	3	4	13
Coordinators State Programs of MR	1	4			1	4									1	4			4	17			1	4							1	4	15	63
Community D. D. Directors	5	11	1	2	3	6	2	5			3	6	6	13	2	5	5	11	3	6	3	6	1	2	1	2					3	6	9	19

LEGEND:

1-Less than $250,000

2-251,000 to 300,000

3-301,000 to 350,000

4-351,000 to 400,000

5-401,000 to 450,000

6-451,000 to 500,000

7-501,000 to 1,000,000

8-751,000 to 1,000,000

9-1,000,001 to 1,500,000

10-$1,500,001 to 2,000,000

11-2,000,001 to 2,500,000

12-2,500,001 to 3,000,000

13-3,000,001 to 3,500,000

14-3,500,001 to 4,000,000

15-4,000,001 to 4,500,000

16-4,500,001 to 5,000,000

17-More than 5,000,000

III. Administration Manpower and Status Need

Groups	Current Position: Doctorate #	%	Masters #	%	Bachelor #	%	New Positions: Doctorate #	%	Masters #	%	Bachelor #	%
Directors - UAF & MR Centers	98	15	122	18	438	67	27	75	5	14	4	11
Administrators - UAF & MR Centers	65	44	38	25	47	31	4	17	13	54	7	29
Coordinators State Programs of MR	143	5	574	20	2154	75	9	5	101	60	58	35
Governmental Staff	12	29	5	12	24	59	2	29	2	29	3	42
Graduate Program Directors	43	6	216	28	502	66	10	77	3	23		
Community D. D. Directors	258	21	293	24	662	55	15	11	43	31	80	58
TOTAL	619	11	1248	22	3827	67	67	17	167	43	152	40

GROUP MEANS

Variables	Directors	Adminis.	Coord. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Organizational Planning	4.63	4.87	4.58	4.69	4.71	4.79	1.0000
Program Planning	3.81	3.97	4.00	4.25	4.25	4.09	1.0000
Decision Making	3.78	4.33	4.19	4.62	4.33	4.28	0.0426
Policy Making	4.11	4.40	4.58	4.25	4.42	4.47	1.0000
Nature and Purpose of Organization	4.26	4.40	4.31	4.31	4.42	4.57	1.0000
Scope of Management Authority	4.15	4.67	4.04	4.56	4.12	4.21	0.1146
Assignment of Activities	3.52	4.10	3.65	3.94	3.58	3.60	0.0927
Determination of Line-Staff Relationship	3.81	4.37	3.88	3.87	3.92	3.96	0.3837
Provision of Support Services	4.15	4.70	3.15	3.81	3.46	3.38	0.0000
Structuring of Committees	3.37	3.67	3.19	3.50	3.46	3.36	1.0000
Personnel Administration	4.11	4.83	3.27	3.75	3.21	3.72	0.0000
Recruitment Procedures	4.00	4.43	2.92	3.69	2.92	3.36	0.0000

P - Values below the 0.05 level indicates significant group mean differences.

GROUP MEANS

Variables	Directors	Adminis.	Coord. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Supervision & Training	3.26	3.83	3.27	3.37	2.87	3.49	0.0103
Performance Evaluation & Promotions	3.93	4.07	3.62	3.75	3.50	3.55	0.1745
Employer-Employee Relationship	4.26	4.60	3.85	4.12	3.54	3.81	0.0012
Communication of Organizational Goals	4.07	4.27	4.19	4.50	4.50	4.36	1.0000
Facilitate Communication Within Organization	4.11	4.40	3.88	4.00	4.12	4.19	0.3885
Communication With Media	3.41	3.57	3.58	3.25	3.46	3.64	1.0000
Public Relations Communication	3.33	3.57	3.58	3.25	3.25	3.79	0.1338
Leadership Within Organization	4.22	4.43	4.46	4.00	4.37	4.47	1.0000
Leadership Outside The Organization	3.67	3.87	3.92	3.50	4.21	3.79	0.3056
Program Operations	3.30	3.73	3.31	3.37	3.50	3.47	1.0000
Organizational Operations	3.81	4.53	3.73	3.62	3.71	3.98	0.0071
Policies Development	3.70	4.33	4.23	3.94	4.17	4.17	0.2213

P - Values below the 0.05 level indicates significant group mean differences.

GROUP MEANS

Variables	Directors	Adminis.	Coord. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Support Systems	4.11	4.77	3.08	3.75	3.29	3.34	0.0000
Personnel System	4.19	4.67	3.00	3.81	3.46	3.45	0.0000
Financial System	4.52	4.83	3.65	4.19	4.00	4.13	0.0005
Basic Organizational Budgeting	4.52	4.83	3.85	4.06	3.96	4.23	0.0033
Program Budgeting	4.41	4.67	3.62	4.19	3.92	4.04	0.0035
Program Relationships With State Government	3.85	4.07	4.15	3.81	3.75	4.04	1.0000
Program Relationships With Local Government	3.67	3.97	3.69	3.69	3.75	3.72	1.0000
Program Relationships With Other Agencies	3.63	3.93	3.81	3.62	3.67	3.81	1.0000
Dept. Relationships Within The Parent Organiz.	3.70	4.10	3.77	3.81	3.75	4.04	1.0000
Legal Implications Related To D.D. Services	3.81	4.20	3.85	3.62	3.62	4.02	0.3600
Political Matters Related To D.D. Services	3.37	4.00	3.88	3.44	3.62	3.83	0.3146

P - Values below the 0.05 level indicates significant group mean differences.

GROUP MEANS

Variables	Directors	Adminis.	Coord. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Development of Record System	4.22	4.47	3.12	3.69	2.96	3.68	0.0000
Devel. of Policy-Use & Abuse of Confidential Info.	4.63	4.87	4.58	4.69	4.71	4.79	1.0000
Computer Technology of Info.	3.81	3.97	4.00	4.25	4.25	4.09	1.0000
Operational Responsibility Of Data Processing Systems	3.78	4.33	4.19	4.62	4.33	4.28	0.0426
Integration of D.D. Programs With Community	4.11	4.40	4.58	4.25	4.42	4.47	1.0000
Liaison Relationships With Community Health Agencies	4.26	4.40	4.31	4.31	4.42	4.57	1.0000
Represents The Organization or Program to Commun.	4.15	4.67	4.04	4.56	4.12	4.21	0.1146
Basic Organizational Accounting	4.33	4.73	2.31	3.50	2.54	3.04	0.0000
Individual Program Accounting	4.11	4.27	2.12	3.37	2.42	2.87	0.0000
Funds Development-Federal Government	4.33	4.47	3.50	4.06	3.75	3.91	0.0051
Funds Development-State Government	4.41	4.53	3.81	4.06	3.67	4.11	0.0177

P - Values below the 0.05 level indicates significant group mean differences.

GROUP MEANS

Variables	Directors	Adminis.	Coord.. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Funds Development-Local Government	4.22	4.30	3.08	4.06	3.67	3.72	0.0016
Funds Development-Labor & Industry	3.85	4.20	2.81	4.06	3.62	3.32	0.0004
Third Party Payment	4.07	4.63	2.77	3.81	3.50	3.19	0.0000
User Fees Development/ Collection	3.74	4.40	2.50	3.56	2.87	2.83	0.0000
Philanthropy	3.63	3.93	2.62	3.44	3.71	3.15	0.0009
Cost Benefit Analysis	4.41	4.63	3.00	4.06	3.67	3.81	0.0000
Manpower Development	3.63	4.13	3.15	3.44	3.54	3.60	0.0480
Impact on Economic Factors on the Supply of D.D. Srvs.	3.70	4.23	3.38	3.69	3.17	3.79	0.0333
Relationship-Economic Status-Need for D.D. Srvs.	3.56	4.23	3.46	3.44	2.83	3.60	0.0060
Program Relationships With Federal Government	3.85	4.07	3.81	3.81	3.71	3.68	1.0000
Determines & Identifies Community Needs	3.52	4.10	3.65	3.94	3.58	3.60	0.0927

P - Values below the 0.05 level indicates significant group mean differences.

GROUP MEANS

Variables	Directors	Adminis.	Coord. State Prog.	Gov't Staff	Grad. Prog. Directors	Commun. D.D. Dirs.	P
Determines Commun. Resources for D.D. Srvs.	3.81	4.37	3.88	3.87	3.92	3.96	0.3887
Determines Types & Extent Of Evalua. Srvs. for D.D.	4.15	4:70	3.15	3.81	3.46	3.38	0.0000

P - Values below the 0.05 level indicate significant group mean differences.